VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
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Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 26, 2013

Mr. Steven Doe, Administrator
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476

Provider #0197

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the unannounced on-site complaint investigation and one entity self-report conducted on November 18, 2013 and concluded on **November 27, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

RECEIVED Division of DEC 19 13 Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0197	A. BUILDING: _____ B. WING _____	C 11/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE MEADOWS	1 PINNACLE MEADOWS RICHFORD, VT 05476

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site visit was conducted by the Division of Licensing and Protection on 11/18/13 to investigate one complaint and one entity self-report. The investigation concluded on 11/27/13. The following regulatory violation was identified.	R100		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interviews the facility failed to protect all residents from the physical abuse of another resident who had been previously identified with aggressive behaviors. (Resident #2). Findings include: Per review, conducted on 11/18/13, Resident #1's care plan, dated 7/12/13, reflected "Potential to cause harm to others" and indicated that Resident #1 had pushed another resident "when [s/he] came into my room so now I can be aggressive a lot more without reason and you can not redirect me...." Approaches identified included: provide redirection when agitated/angry; call family member to talk to [him/her]; provide time-out; if nothing working and if threat of harm to others remains notify nurse and administration. Despite the evidence that Resident #1 had previously been involved in a physical altercation with another resident, a Nurse Progress Note,	R224	(PLEASE SEE ATTACHED)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

- STEVEN A. Joe — ADMINISTRATOR — 12/18/13

R224 POC attached, accepted 12/26/13 BHaverN/PMC

PMC

Division of Licensing and Protection

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R224	Continued From page 1 dated 9/28/13 at 6:15 AM, stated Resident #1 had exited his/her room that morning and struck Resident #2 who fell backwards onto the floor. Resident #2 was transported to the ED (Emergency Department) for evaluation and treatment of what was identified as multiple superficial mild contusions of the left wrist and hand, right knee and scalp. The note further indicated that, following the incident, Resident #1 had verbally threatened staff, using a "fork and stabbing motions to show what s/he felt like doing to everybody", and had subsequently been transported to the ED "for [his/her] and other residents safety." Per interview, at 1:00 PM on 11/18/13, the facility Manager confirmed that Resident #1 had pushed another resident, in June of 2013, resulting in injury to that resident. S/he stated it was determined, at that time, that the facility could no longer meet Resident #1's needs as the resident's behavior was very unpredictable and a plan had been developed to find alternate placement for the resident, which, to date, had been unsuccessful. The Manager further confirmed that Resident #1 pushed Resident #2, on the morning of 9/28/13, causing Resident #2 to fall to the floor and resulting in the transfer of Resident #2 to the ED (Emergency Department) for evaluation. This is a repeat deficiency.	R224		

SAD
12/18/13

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
November 27, 2013

R224

6.12

Action: Administrator determined that Resident #1 required an Emergency Discharge for his safety and the safety of other residents. The On-Call Physician for Resident #1 was notified. The Physician provided verbal orders to transport Resident #1 to the Northwestern Medical Center for further evaluation by Emergency Department and the Northwest Counseling and Support Services Crisis Team. The Guardian of Resident #1 was notified and strongly supported the discharge of Resident #1 from Our Lady Of The Meadows.

Measures: Administrator and Nurse Manager developed a policy and procedures to provide on-going protocol for managing challenging behaviors (Please see Attachment 1). The Nurse Manager will review the new "Managing Challenging Behaviors Policy and Procedures" with all Direct Care and Activity Staff to work collectively maintaining an environment free from mental, verbal or physical abuse, neglect and exploitation.

Monitors: Administrator and Nurse Manager will monitor this practice to insure that this deficiency does not occur again.

Date Completed: Dec 12, 2013

managing challenging behaviors POLICY

What needs to happen...

Staff must be skilled in working with confused residents so that challenging behavior is avoided whenever possible, and is handled with dignity and compassion when it occurs.

Why it's important...

Confused residents may occasionally behave in a challenging way due to their condition. The right reaction can make residents feel comfortable and secure.

How to make it happen...

Minimize the discomfort of confused residents. Challenging behavior is often a resident's way of telling you he or she is uncomfortable or unhappy about something. A resident may be afraid, tired, bored, lonely, hungry, or in pain but cannot tell you. Behavior may be your only clue. Your response to a resident can limit challenging behavior.

Some examples of challenging behavior are wandering, agitation, striking out, making unkind comments, repetitive behavior, and inappropriate sexual behavior.

Wandering:

Make sure the resident gets exercise and activity during the day. Be sure that wandering does not occur because the resident is hungry or looking for the bathroom. If the behavior is new, check to see if a new medication might be causing it or when the resident last moved their bowels.

Wandering can be dangerous for the resident or interfere with the rights of other residents (such as wandering into another resident's room). Encourage a resident who wanders to do so in a way that is safe.

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Agitation, Striking Out, Making Unkind Comments:

Do:

1. Try to determine the cause of the challenging behavior.
    a. Offer Foods, Drinks
    b. Take to Bathroom
    c. Look for signs of pain
    d. Lie down for a nap
2. Be supportive and encouraging.
3. Use The Validation Technique to address the resident's concerns
4. Clearly communicate with the resident using like tone and good eye contact.
5. Use positive expressions such as:
    a. Please.
    b. Thank you.
    c. Let me see if I can help.
6. Reduce stimulation; for instance, turn off radios, televisions, anything that is making a loud noise.
7. Remove from crowded areas.

In the case where staff intervention has been unsuccessful, the nurse will notify/consult with the Physician, the resident's Families/POA's/Guardians and management to decide a plan of action that is based on the wants and needs of the residents.

Do not:

1. Scold the resident.
2. Humiliate the resident.

TIP

- Warning signs of agitation include:
    - ✓ Frowning.
    - ✓ Pacing.
    - ✓ Waving arms.
    - ✓ Speaking loudly.
    - ✓ Rattling doorknobs.
    - ✓ Wringing hands.
    - ✓ Scowling.
    - ✓ Shaking fists.
    - ✓ Backing away from others.
    - ✓ Trying to leave the building.
    - ✓ Being unable to sit still or rest.

3. Force a resident to do a task.
4. Intimidate the resident.
5. Restrain the resident.
6. Corner or crowd the resident with too many staff.

Repetitive Behaviors:

Actions that someone performs continuously or on a repeated basis:

1. Let the resident perform the behavior if it isn't hurting him or her or others or disturbing others.
2. Look behind the behavior and try to understand what is causing it.
3. Calm fears, provide a quiet atmosphere, talk with him or her, give the resident a task to do.

Acceptable vs. Unacceptable Sexual Behavior:

In the case of displays of affections between residents when one is mentally competent and the other has a medical diagnosis of dementia, Alzheimer's Disease or any other condition in which the resident is not deemed competent to make decisions for him/herself; the staff will make every effort to intervene in order to protect the right of the individuals involved and notify the Nurse as soon as possible.

In the case of two residents when both are deemed incapable of making decisions for themselves, the staff should observe carefully, intervene as necessary and notify the Nurse as soon as possible.

Some behaviors that are considered **appropriate** are the following:

1. Hand holding
2. Sitting Close together and having arms around each other to the extent that neither resident is expressing or appears to be uncomfortable with the situation.
3. Brief kissing to the extent that neither resident is expressing or appears to be uncomfortable with the situation.

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The staff should be able to observe these residents at all times, either in a common area or in their rooms with the doors open.

Some behaviors that are considered **inappropriate** are the following:

1. Prolonged Kissing
2. Fondling
3. Disrobing
4. Vulgar or suggestive language
5. Any type of sexual intercourse

The staff should intervene to prevent this behavior without over reacting, embarrassing or humiliating the residents and notify the nurse as soon as possible. The nurse will be responsible for notifying the Families/POA's/Guardians of the residents involved.

Interventions could include:

1. Separating the individuals
2. Redirection and using the Validation Technique
3. Encouraging the joining of group or individual activities
4. Offering a snack
5. One to One with staff or family
6. Music/TV
7. Going for a walk with a staff member

In the case where staff intervention has been unsuccessful, the nurse will notify/consult with the Physician, the resident's Families/POA's/Guardians and management to decide a plan of action that is based on the wants and needs of the residents.

Public displays of masturbation, undressing, and inappropriate touching:

1. Residents may masturbate because they may no longer be aware of appropriate times or places for sexual behaviors or their sexual needs are not being met.

2. Residents may undress because their clothes are too tight, their clothes may be itchy or uncomfortable, or they may be too warm.

3. Residents may touch themselves because they need to go to the bathroom, they have a urinary tract infection (UTI), they have a rash, or it feels good, and they have lost the ability to judge the appropriateness of their own behavior.

4. Residents may touch others because they misunderstood or misinterpreted staff ("Shall we get your bath?" "Let's go to bed."), they have lost their inhibitions, or they are being flirtatious.

There are many ways that you can help a confused resident who displays inappropriate sexual behaviors. Don't take the behavior personally, but look to see if you may have done something that could be misinterpreted.

You can help by:

1. Remembering to act in a way that preserves the resident's dignity.

2. Do not overreact and approach the resident in a calm manner.

3. Try using the Validation Technique to help alleviate the situation.

4. Do not scold the resident.

5. Do not embarrass or humiliate the resident.

6. Do not force a resident to do a task.

7. Do not intimidate or restrain the resident.

8. Do not corner or crowd the resident with too many staff.

9. Never judge a resident because of the behavior.

10. Discretely offering privacy to the resident.

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11. Checking the resident's groin area for a rash or urinary tract infection (UTI).

12. Remembering that the behavior may be caused by the need to use the bathroom — try escorting the resident to the bathroom.

13. Trying to find out what is causing the behavior. For instance, are the resident's clothes too tight?